

UNUSUAL PRESENTATION OF A TUBAL PREGNANCY : A CASE REPORT

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Summary

Ectopic means "out of place." In a normal pregnancy, the fertilized egg implants and develops in the uterus. In most ectopic pregnancies, the egg settles in the fallopian tubes. This is why ectopic pregnancies are commonly called "tubal pregnancies." None of these areas has as much space or nurturing tissue as a uterus for a pregnancy to develop. As the fetus grows, it will eventually burst the organ that contains it. This can cause severe bleeding and endanger the mother's life. A classical ectopic pregnancy does not develop into a live birth. The tube is capable for only limited distention and is unable to provide secure placentation also due to unsatisfactory environment, 80% of these embryo are malformed and more than 99% of these do not progress beyond 6 weeks of pregnancy. A 25 years lady para 1+1 (Ectopic pregnancy) present as an emergency patient with history of pregnancy of 4 months with shock. immediate resuscitation, intubation and laparotomy was done for high intuition towards ectopic pregnancy. It was great surprised that there was a near about 16 weeks size of foetus coming out from the ruptured tube and the tube was hugely distended about 10 cm diameter. After laparotomy the patient was recovered well. The case is reported here as a very rare entity and near miss mortality.

Key words: Ruptured tubal pregnancy; Ectopic pregnancy; near miss mortality.

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Introduction

Tubal pregnancy is a pregnancy that is not in the usual place within the uterus but is located in the Fallopian tube. Tubal pregnancies are due to the inability of the fertilized egg to make its way through the Fallopian tube into the uterus [1].

Most tubal pregnancies occur in women 35 to 44 years of age [2]. Tubal pregnancies are the most common type of extrauterine or ectopic pregnancy, accounting for the large majority (95%) of all extrauterine pregnancies [3]. Ampullary portion of the tube is the commonest and least dangerous site of tubal pregnancy. The tube is capable for only limited distention and is unable to provide secure placentation also due to unsatisfactory environment, 80% of these embryo are malformed and more than 99% of these pregnancies do not progress beyond 6 weeks of pregnancy [3,4]. The fallopian tube may rupture due its thin lumen at isthmas than ampulla. The lumen is incapable of distention due to the blastocyst burrowing and eroding the tubal wall. Rupture of the tube usually causes severe bleeding and complete or partial extrusion of chorionic villi leading to haemodynamic unstable patient presenting with shock like features [5]. A patient with amenorrhoea, pain and vaginal bleeding should always be suspected to have an ectopic pregnancy. The dictum to early diagnosis and successful management is to "think ectopic" but also not to "over think ectopic" [6]. Ruptured ectopic pregnancy carries risk of maternal mortality upto 2.2% [7,8].

Case Report

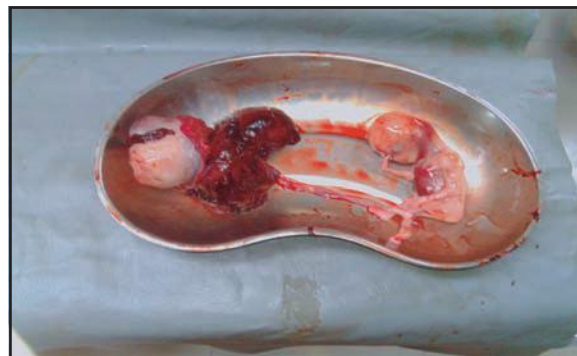


Fig 1 : Well for med foetus of 16 weeks

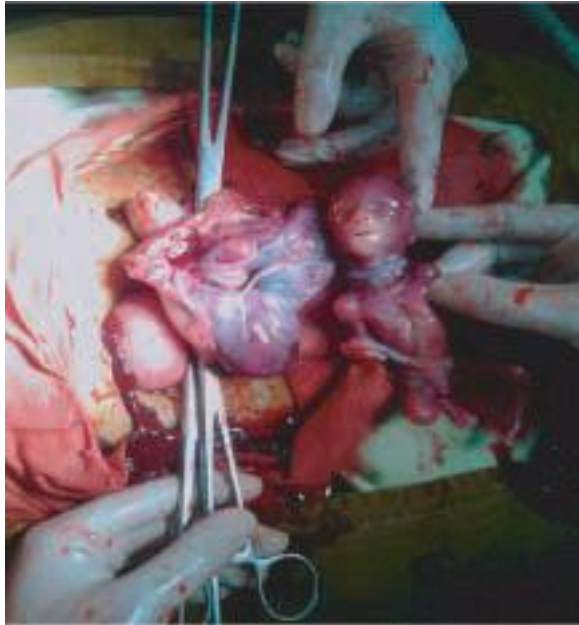


Fig 2 : Foetus and placenta attached with fallopian tube

Mrs. "A" 25 years old, para 1+1 (Ectopic pregnancy), age of her last child was 6 years, hailing from Shitakundu, Chittagong admitted into Chittagong Medical College Hospital (CMCH) on 3/6/14 at 5:00 pm as an emergency obstetric patient with the complaints of pregnant for 4 months with shock & respiratory distress.

Initially she went to a local doctor for her abdominal pain with pregnancy of four months. She was a regularly menstruating woman and her LMP was 7.2.14. Though it was her spontaneous conception but she was trying for conception for last two years. After examine the patient, the doctor advised her to do an ultrasonography (USG) and USG report reveals a single alive intrauterine pregnancy of 14 weeks. The patient was treated with oral antibiotic and anti spasmotic with the thinking of pregnancy with urinary tract infection. When she returned home, her condition was deteriorating and she felt chocky pain in her chest followed by fainting attack. Then patients relatives bought her to CMCH for better management. On admission, she looks average body built but she was severely anaemic, respiratory rate was 60 beat/min, pulse and blood pressure were non recordable condition and profuse sweating was there. Abdomen was tense, tender and moderately distended, on pervaginal examination- It was so tender that size of uterus and adnexa couldn't be delineated. There

was no pervaginal bleeding and cervical dilation. With high intention of suspicion about ectopic pregnancy, she was clinically diagnosed as a case of ectopic pregnancy and immediate decision was taken for laparotomy. Patient developed gasping respiration, so immediate intubation was done. Resuscitation and laparotomy was done simultaneously. On laparotomy, huge amount of clotted, nonclotted and flesh blood was found within the peritoneal cavity. After clearing the peritoneal cavity it was found that left fallopian tube was dilated and ruptured at ampullary region. The distended portion was approximately 10 cm. There was continuous bleeding from ruptured site. A fetus of about 16 weeks size was found just behind left adnexae which was attached with cord and placenta and the placenta was adherent with ruptured part of tube. Now, she was diagnosed as a case of ruptured tubal ectopic pregnancy. Left sided salpingectomy was done. No residual placental tissue was retained within the pelvic cavity. Exploration was done all over the abdomen. Both ovaries and right Fallopian tube were healthy. Peritoneal toiletting was done with 3 litre of normal saline. Proper haemostasis was maintained, a drain was kept in situ. Abdomen was closed in layers. Post-operatively she was managed with antibiotic injection Ceftriaxon (1gm) twice daily and Metronidazole (500 mg) thrice daily for 7 days, analgesics and continuous catheterization for 24 hours. Peroperatively 2 units of blood was transfused, post-operative another 1 unit also transfused and injection calcium gluconate was given. Her post-operative period was uneventful and on her 8th POD, she was discharged from hospital with advice of deferment of pregnancy for at least 1 year.

Discussion

Ectopic pregnancy: In an ectopic pregnancy, the developing embryo does not implant on the endometrial wall, but instead attaches to some other surface [9]. For ninety eight percent of pregnancies outside the uterus, that surface is within the fallopian tube. This is also called a tubal pregnancy [10]. In our case the embryo also implants within the fallopian tube. There is no way to save an ectopic pregnancy. It cannot turn into a normal pregnancy [11]. If the egg keeps growing in the fallopian tube, it can damage or burst the tube and cause heavy bleeding that could be deadly. If you have an ectopic pregnancy, you will need quick treatment to end it before it causes dangerous problems. An ectopic pregnancy

can't proceed normally [12]. The fertilized egg can't survive, and the growing tissue might destroy various maternal structures. Left untreated, life-threatening blood loss is possible. Early treatment of an ectopic pregnancy can help preserve the chance for future healthy pregnancies [13].

In the mid-nineteenth century, when ectopic was rare but universally fatal condition [14]. With the improvement of surgical techniques at the turn of twentieth century, ectopic pregnancy become curable [15]. However it is still considered a very serious problem with high mortality rates. This perception has only be changed recently with the increase ability to establish the diagnosis of ectopic pregnancy non invasively in women with minimal clinical symptoms. In our case we diagnose it absolutely clinically. there are so many risk factors predisposing to tubal pregnancies includes Pelvic Inflammatory Disease (PID) surgery on a fallopian tube, prior tubal pregnancy, history of repeated induced abortions, history of infertility problems or medications to stimulate ovulation, congenital malformation (A birth defect) of genital tract. In our case the patient was suffering from secondary subfertility for the last two years [1,16].

Site of the tubal pregnancy excluding the tubal stump pregnancy, the ovum implants one of the four main positions- frimbriated opening : a primary implantation at this site is unusual (17%) ampulla: this is the commonest and least dangerous site (55%), here we see in our case the embryo also implants at the ampullary portion of the tube. isthmus: this is less common but more dangerous because of likelihood of tubal rupture (25%) and interstitial: this is probably rare although some case may be missed because pregnancy can be discharged through the uterus. It is said to be site about 3% of tubal pregnancy [17].

The tube is capable for only limited distention and usually this condition will lead to disaster in one of the following ways: 1) Tubal rupture 2) Tubal abortion 3) Complete absorption 4) Tubal blood mole or carneous mole. Our patient also presents with ruptured ectopic pregnancy. More than 99% of pregnancies do not progress beyond 6 weeks but it is unusual in our case where the pregnancy continued upto 16 weeks of pregnancy.

A major concern with a tubal pregnancy, as with any ectopic pregnancy, is internal bleeding. If there is any doubt, seek medical attention promptly.

Pain is usually the first symptom of a tubal pregnancy [2,3,18]. The pain, often one-sided, may be in the pelvis, abdomen or even in the shoulder or neck (due to blood from a ruptured tubal pregnancy building up under the diaphragm and the pain being "referred" up to the shoulder or neck). our patient initially suffering from pain followed by fainting attack. The pain is usually sharp and stabbing. Weakness, dizziness or lightheadedness, and a sense of passing out upon standing can represent serious internal bleeding, requiring immediate medical attention [19].

Diagnosis of a tubal pregnancy includes a pelvic exam to test for pain, tenderness or a mass in the abdomen. The most useful laboratory test is the measurement of the hormone hCG (human Chorionic Gonadotropin). In a normal pregnancy, the level of hCG doubles about every two days during the first 10 weeks whereas in a tubal pregnancy, the hCG rise is usually slower and lower than normal. Ultrasound can also help determine if a pregnancy is ectopic, as may sometimes culdocentesis, the insertion of a needle through the vagina into the space behind the uterus to see if there is blood there from a ruptured Fallopian tube [20].

Treatment of a tubal pregnancy may be medical or surgery according to the outcome of ectopic, if it is diagnose before rupture then medical treatment can be implemented [4,5,6]. Early detection of ectopic pregnancy, desire to improve fertility, minimising cost and the surgical morbidity are the main reasons for incorporating medical treatment in the spectrum of therapeutic option for ectopic pregnancy [15,17]. Surgery either by laparotomy or by laparoscopy. Today to remove the ill-fated pregnancy a ruptured tube usually has to be removed. If the tube has yet not burst, it may be possible to repair it.

The prognosis (out look) for future pregnancies depends on the extent of the surgery. If the Fallopian tube has been spared, the chance of a successful pregnancy is usually better than 50%. If a Fallopian tube has been removed, an egg can be fertilized in the other tube, and the chance of a successful pregnancy drops somewhat below 50% [21].

Conclusion

Ectopic pregnancy is one of the common and serious problem with significant morbidity rate and a potential for maternal death. Many a times the risk factor and classical clinical features of ectopic pregnancy may not be present. Ultrasonography and beta-hCG measurement play an important role not only in diagnosis but also in the management. Strict adherence to criteria for particular mode of management ensures increase success rate.

Disclosure

All the authors declared no competing interest.

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